MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

March 2003

DATA SYSTEMS & ANALYSIS

Data Base and Application Development

Internet-Based Re-Licensure Applications
MHCC has agreed to assist the Maryland Board of Physician Quality Assurance (BPQA) in further developing BPQA's Internet-based re-licensure tool. Last year, the MHCC staff developed a renewal application and then released the product to BPQA who was responsible for operations. This year, MHCC will incorporate additional security and documentation features, as well as enhancing technical components that will allow America-Online users to more efficiently use the application. One FTE will be dedicated to this project for approximately 3 weeks. MHCC will not incur any other costs associated with this contract.

MHCC's continued interest in supporting BPQA is driven by an interest in reducing data entry costs associated with entering the MHCC portion of the BPQA renewal (MHCC collects information on physician characteristics from the paper re-licensure applications). The Internet application will ultimately virtually eliminate data entry costs. In the 2002, the first year of use, over 40 percent of renewing physicians used the Web site to renew their licenses. The Bank of America and the Metavante Group are partners with MHCC and BPQA on the development of a renewal system.

The Board of Pharmacy has requested that MHCC develop a pharmacist's license renewal application. This application will complement the pharmacy license renewal process that MHCC developed in December.

2002 Ambulatory Surgery Survey
The Commission will release the survey in April to approximately 300 ambulatory care facilities in Maryland. The data will be used to support a variety of health planning activities at MHCC. Other data collected from this survey will be used in the hospital and ambulatory surgery quality reporting initiatives. Ambulatory care facilities will have 45 days to complete the survey.

Cost and Quality Analysis

Practitioner Report
The staff will release ***Practitioner Utilization: Trends within Privately Insured Patients from 2000 to 2001.*** The report examines payments to physicians and other health care practitioners for care provided to privately insured Maryland residents under age 65. Analysis is based on the health care claims and encounter data that private health insurance plans serving Maryland residents submit annually to the Maryland Health Care Commission as part of the Medical Care Data Base. Among the principal findings:

- Overall private practitioner spending grew by approximately 10 percent 2000 to 2001. The jump was due to increases in the quantity of care and greater intensity of service. On

average, the report found that the prices paid to practitioners were unchanged from 2000 to 2001. Practitioner payments have essentially been stable since 1999.

- Rates paid by private insurers in 2001 were about 98 percent of Medicare's rates. In 2000, the MHCC reported that private rates were about 104 percent of Medicare. The primary cause for the decline is the 5 percent increase in Medicare reimbursement that occurred in 2001. For visits, the average private rates were slightly below Medicare rates, while for other services, private rates were modestly to substantially higher than Medicare rates. Across the country, overall private payer rates range from slightly below Medicare to significantly above Medicare rates.

- On average, HMOs paid slightly lower rates than non-HMO products in 2001. HMO rates averaged about 96 percent of Medicare compared to 99 percent for non-HMOs. The biggest difference between HMO and non-HMO rates was for payment of services performed by nonparticipating physicians, that is, physicians not under contract to the plan. For those physicians, HMOs paid substantially lower amounts per relative value unit (RVU) of care than did non-HMO plans. However, the analysis found that HMOs have made significant progress in complying with recent changes to Health-General Article § 19-710.1 that requires HMOs to pay nonparticipating physicians at least 125 percent of the rate paid to their participating physicians.

EDI Programs and Payer Compliance

EHN-Certification

MHCC will consider applications from HDX and Per Se Technologies for electronic health network certification. HDX markets hospital management information systems that include clearinghouse support to the hospital industry. The company recently signed an agreement with a consortium of Maryland hospitals to develop a Web-portal to support the transmission of Medicaid eligibility information to participating hospitals. The second organization, Per Se Technologies seeks to renew its EHN certification for another 3 years. Per Se has been active in the Maryland market since 1997.

Staff continues efforts to interest other national clearinghouses in doing business in Maryland on the belief that more competition will lower costs for providers. Passport Health, a leading national clearinghouse, is how pursuing national accreditation and will seek Maryland certification. Staff also provided information to support the Claims Processing Company (CPC), a national dental electronic health network, in their efforts to learn more about MHCC certification requirements. CPC is one of the largest dental networks in the nation and is considering entering the Maryland market.

HIPAA Compliance Efforts

CMS Final Security Rule Released

HHS published the Final Security Rule with an effective date of April 21, 2003 and a compliance date of April 21, 2005. The effective date for security will be nearly 2 years after the compliance date for the HIPAA privacy regulations. The final security regulations define a relatively realistic model for security management that is broadly flexible across the health care industry. Nonetheless, most covered entities will find these regulations the most challenging to implement of all HIPAA requirements. Despite the increased flexibility, covered entities should not take the flexibility provisions of the rule as a reason to ignore the technological side of security. HHS has stated that this flexibility does not extend to non-compliance, as appropriate technical measures

will be needed in order to implement many of the rule's provisions. MHCC has released a Security Assessment Tool aimed to assist small providers in meeting the security regulations.

HIPAA Compliance Education
Efforts to educate organizations on HIPAA privacy requirements are continuing. Staff developed sample HIPAA consent and authorization forms that were added to the Commission's *Guide for Privacy Assessment, v2*. On average, MHCC hosts three seminars per week on complying with the privacy requirements. During late February and early March, staff held training or provided HIPAA support to the following organizations:

- Presented on HIPAA's privacy requirements to the medical staff at **Union Memorial Hospital**. Staff was invited to review the privacy requirements at an event coordinated by the hospital for physicians practicing at Union Memorial.
- Reviewed HIPAA privacy documents developed by **Atlantic General Hospital**. Atlantic General requested guidance from staff as it relates to the completeness of their privacy documentation.
- Provided consultative support to **Practice Management Partners**, a local professional billing organization in implementing the HIPAA requirements.
- Provided consultative support to **Software Unlimited**, a practice management software vendor and Maryland small business, in understanding HIPAA's privacy and transaction standard requirements. Approximately 2,000 providers use Software Unlimited products statewide.
- Met with representatives from the **Maryland Board of Acupuncture** to discuss the impact of HIPAA on their members. The Board is developing a compliance manual for their members and asked for guidance in developing the document.
- Presented on EDI/HIPAA at **Blue Ridge Behavioral Health Clinic** during a regional meeting on HIPAA for behavioral therapists in the Hagerstown.
- Presented on HIPAA at a regional **EPIC Pharmacy** conference. EPIC Pharmacy set up five regional conferences on HIPAA around the state.
- Provided EDI awareness training to several **small home health organizations**.
- Acted as a HIPAA consultant to **NeighborCare Pharmacies** in developing their HIPAA compliance workforce-training program. NeighborCare Pharmacies is developing an in-house program for workforce training in Maryland.
- Provided feedback to **Carroll County General Hospital** (CCGH) regarding their HIPAA compliance program. CCGH requested staff input on a number of activities related to implementing HIPAA's privacy and transaction requirements.
- Acted as an industry consultant to approximately **100 physicians and/or their practice administrators** on questions relating to HIPAA.
- Provided assistance to **Montgomery County Medical Society** in developing a forms package for practice administrators relating to HIPAA privacy.
- Presented on HIPAA to the membership of the **Eastern Shore MGMA**. Approximately 80 office managers attended the meeting.
- Staff met with representatives of the **Mid-Atlantic Health Information (MAHI)** organization to present and share the Commission's EDI/HIPAA education strategies.

EDI/HIPAA Work Group
A work group meeting was held on March 4th to discuss the recent release of the final Security Rule and to continue work on a transaction assessment guide. The transaction guide has two purposes: (1) assist medical practices in carrying out internal assessments for meeting the required collection of information under HIPAA's new standards transaction and code sets, and

(2) provide a reference document that can be used by medical practices to validate practice management vendor compliance in modifying software to meet HIPAA requirements. The Work Group intends to complete this guide by late May so that practices can begin using the information in June.

PERFORMANCE & BENEFITS

Benefits and Analysis

Comprehensive Standard Health Benefit Plan (CSHBP)
At the November 2002 meeting, the Commission approved the proposed regulations to implement one change to the CSHBP, previously voted on at the October 2002 meeting: coverage for residential crisis services. The proposed regulations were published in the *Maryland Register* on January 24th. The comment period ended on February 24th. No public comments were received. The Commission will be asked to provide final approval of the regulations at the March meeting. Upon approval, this change will be implemented effective July 1, 2003.

On January 31st, Commission staff mailed survey packets to all carriers participating in the small group market in Maryland to collect their annual financial data. The deadline for carriers to submit this data is April 4th. Staff will complete an analysis of the survey results, including number of lives covered, number of employer groups purchasing the CSHBP, loss ratios, average premiums as they relate to the 12-percent affordability cap, etc. Staff will present these findings to the Commission in the spring.

Commission staff has developed a website to be used as a guide for small business owners in their search for health insurance for their employees. This "Guide to Purchasing Health Insurance for Small Employers" is available on the Commission's website at: www.mhcc.state.md.us/smgrpmkt/index.htm. Commission staff is in the process of developing a bookmark describing information available on the small group website. This bookmark will be presented to the General Assembly during the 2003 legislative session.

Evaluation of Mandated Health Insurance Services
At the November meeting, Mercer presented its evaluation of mandated health insurance services as to their fiscal, medical and social impact, along with all proposed mandates that failed during the 2002 General Assembly session to the Commission for release for public comment. At the December meeting, the Commission approved the report for release to the legislature, after some modifications to the Executive Summary. The final report was sent to the General Assembly in January 2003, and is available on the Commission's website at: www.mhcc.state.md.us/cshbp/mandates/finalmercerreport02.pdf.

High-Risk Pool (MHIP)/Substantial Available and Affordable Coverage (SAAC)
In 2002, the General Assembly enacted and the Governor signed HB 1228 under which the SAAC program and the Short-Term Prescription Drug Subsidy Program will be replaced with the Maryland Health Insurance Plan Fund and Senior Prescription Drug Program. Both will be administered by the newly created Maryland Health Insurance Plan (MHIP), an independent agency within the MIA. The Executive Director of the MHCC is a member of the Board. The MHIP Fund is financed through a proportionate assessment on hospital net patient revenue that would equal the CY 2002 SAAC funding. The new program is required to be operational on July

1, 2003, and hospitals must begin paying the assessment as of April 1, 2003 in order to fund the start-up. The MHIP Board is responsible for running the programs.

The MHIP Board has selected Maryland Physicians Care (MPC) as the MHIP contract administrator. As contract administrator, MPC will review applications from potential members, collect premiums, and pay health insurance claims for MHIP. MPC is owned by four Maryland community health systems: Maryland General Health Systems in Baltimore, Washington County Health System in Hagerstown, Western Maryland Health System in Cumberland, and St. Agnes HealthCare in Baltimore.

Carriers must report to the MIA the number of applications for medically underwritten individual policies that they have declined. The Senior Prescription Drug Program is funded through enrollee premiums and a subsidy by a nonprofit health service plan (CareFirst) not to exceed its premium tax exemption. The MHCC is no longer responsible for developing the benefit plan. The MIA required CareFirst (Maryland and D.C.) to have the last SAAC open enrollment in December 2002. CareFirst complied by advertising the open enrollment period in local newspapers throughout the month of December 2002.

Legislative and Special Projects

HRSA Grant - Uninsured Project

In June 2002, DHMH, in collaboration with MHCC and the Johns Hopkins School of Public Health, was awarded a $1.2 million State Planning Grant by the Health Resources and Services Administration (HRSA). HRSA is the federal agency that oversees programs to ensure access to care and improve quality of care for vulnerable populations. The one-year federal grant provides Maryland with substantial resources to examine the state's uninsured population and employer-based insurance market and to develop new models to make comprehensive health insurance coverage fully accessible to all Maryland residents.

Among the several activities, the one year grant will enable DHMH and MHCC to conduct further analysis of existing quantitative data sources (Maryland Health Insurance Coverage Survey, MEPS-IC, and CPS), as well as collect additional data that will help us design more effective expansion options for specific target groups. In addition, we have conducted focus groups with employers in order to better understand the characteristics of firms not currently participating in the state's small group market. For those firms currently participating in the CSHBP, issues will be probed relating to costs of coverage and knowledge of the base CSHBP. In an effort to increase the take-up rate in the small group market, marketing materials were presented to the focus groups for review and modification. Shugoll Research was selected as the vendor to conduct these focus groups. The focus groups were completed on Friday, February 14, 2003, with over 70 employers and 20 brokers participating. A report summarizing the findings from the focus groups will be made available in late March.

A second meeting with the Health Care Coverage Workgroup was held on March 3, 2003. This group is comprised of members who represent of the provider, business, health care advocacy, and health care research communities in the state. A list of 20 public and private sector option strategies was presented to the group for discussion. The next meeting with the Workgroup will be held on April 11 in Annapolis.

The grant team requested a no cost extension of the project timeline, with an interim report due to the Secretary of the Department of Health and Human Services in June 2003 and the final report

submitted in December 2003. The final report must outline an action plan to continue improving access to insurance coverage in Maryland.

Patient Safety

Chapter 318 (HB 1274) of 2001 requires the Commission, in consultation with DHMH, to study the feasibility of developing a system for reducing preventable adverse medical events. A Maryland Patient Safety Coalition was initiated by the Delmarva Foundation and served as the Commission's sounding board for its activities related to patient safety. Three workgroups were formed: one to look at issues related to systems changes to be recommended; one to address current regulatory oversight and reporting requirements; and a third to discuss issues related to a proposed Patient Safety Center.

A preliminary report, approved by the Commission at the December 2001 meeting, was sent to the General Assembly. One of the preliminary recommendations has been enacted by the General Assembly and signed by the Governor. That bill removes the medical review committee statute that applies to all health care practitioners from the BPQA statute, where it is currently codified, and places it in a separate subtitle within the Health Occupations Article to make practitioners more aware of the protections available to them. It also codifies case law to clarify that certain good faith communications designed to lead to remedial action are protected even when they are not made directly to a medical review committee or committee member, but are nevertheless designed to remedy a problem under the jurisdiction of a medical review committee. The final report has been approved by the members of the Commission and was submitted to the members of the Maryland General Assembly in January. Commission staff has briefed two Legislative Committees — the House Health and Government Operations Committee and the Senate Education, Health, and Environmental Affairs Committee — on the study. A bill has been approved by the House to grant medical review committee status to the Maryland Patient Safety Center, as designated by the Commission. This bill would grant protections against legal liability and disclosure of information. The bill is now in the Senate Finance Committee.

In addition, Commission staff, along with the University of Maryland Office of Research and Development, LogiQ (a non-profit research entity affiliated with the Maryland Hospital Association) and the Delmarva Foundation recently submitted a proposal for a federal grant that would fund the creation of a Patient Safety Center. The grant proposal was submitted October 1, 2002.

Facility Quality and Performance

Nursing Home Report Card

Chapter 382 (SB 740) of 1999 requires the Commission, in consultation with the Department of Health and Mental Hygiene and the Department of Aging, to develop a system to comparatively evaluate the quality of care and performance of nursing facilities. The web-based Nursing Home Performance Evaluation Guide is available through the Commission's website. The Guide includes a Deficiency Information page, data from the Minimum Data Set (MDS) and the MHCC Long Term Survey, as well as an advanced search capability, allowing consumers to search by facility characteristics and certain services.

The Commission participated in the Centers for Medicare and Medicaid Services (CMS) pilot program with five other states from April though early November 2002. At the conclusion of the pilot, CMS conducted a national rollout of the CMS Nursing Home Quality Initiative on November 12, 2002. The Commission's website was subsequently updated in January 2003 to reflect the final CMS Nursing Home Quality measures. The website was also updated to include

quality indicator data from January through June 2002. Seven of the 10 quality measures reported on the CMS website are featured on the Maryland Guide in the same format as the current Quality Indicators are, utilizing the symbols that separate the top 20%, bottom 10% and all others. CMS is reporting two new measures and one revised measure that are risk-adjusted using a Facility Adjustment Profile (FAP). Two of these measures are currently featured on the Guide without the FAP (Prevalence of Stage 1-4 pressure ulcers for chronic care and Failure to improve/manage delirium for post acute care) as recommended by the Hospital Report Card Steering Committee.

Hospital Report Card

Chapter 657 (HB 705) of 1999 requires the Commission to develop a similar performance report on hospitals. The required progress report has been forwarded to the General Assembly. The Commission has contracted with the Delmarva Foundation, in partnership with Abt Associates, to: (1) analyze hospital data to develop appropriate indicators for inclusion in the Hospital Performance Evaluation Guide, and (2) design and execute a consumer-oriented website for the Guide. The initial version of the Hospital Performance Evaluation Guide was unveiled at a press conference on January 31, 2002.

The first iteration of the Hospital Guide features structural (descriptive) information and the frequency, risk-adjusted length-of-stay, and risk-adjusted readmissions rates for 33 high volume hospital procedures (diagnosis related groups or DRGs). Data for those facilities with less than 20 discharges per DRG in the reporting period are not presented.

DRG data was updated in December 2002 to include admissions occurring between December 1, 2000 and November 30, 2001. Three DRGs that were featured previously are not included due to the small number of hospitals that had 20 or more discharges per DRG. Readmission rates for circulatory system diseases and disorders are featured. The formula used to calculate the readmission rates for all DRGs was altered to better define transfers to other hospitals and excludes "planned" readmissions.

Data collection for the two core measure sets (Congestive Heart Failure and Pneumonia) under the Joint Commission on the Accreditation of Healthcare Organization's (JCAHO) ORYX initiative has begun. Data has been gathered on a pilot, or test, basis for the first and second quarters of 2002. Each hospital's information for Quarter One of 2002, along with the state average, is currently available to that particular hospital. The Delmarva Foundation, our contractor for this data collection effort, has been working with the hospitals and ORYX measurement instrument vendors to provide technical assistance for the logistics of transmitting the data and to assist the hospital personnel in understanding the specifications for collecting the data. Data gathered between July and December 2002 (Quarters 3 and 4) will be made publicly available in the second iteration of the Hospital Guide in Spring 2003.

The Delmarva Foundation was awarded the 'lead state' to head a three-state hospital public reporting pilot project initiated by CMS. Delmarva will assist CMS with the following:

- Test the collection and reporting of the JCAHO/CMS performance measure sets
- Test the AHRQ sponsored standardized patient experience (satisfaction) survey
- Test additional performance measures as determined by the pilot states
- Determine the least burdensome ways for hospitals to meet upcoming public reporting requirements
- Determine how to integrate CMS mandated reporting with existing state level public reporting activities

- Determine how to best involve stakeholders in the development and execution of hospital public reporting activities.

The Hospital Report Card Steering Committee serves as the steering committee for the pilot and has been expanded to include additional rural, minority, payer, and business/employer representatives. The Committee will be the primary vehicle for obtaining input and consensus prior to initiating the state specific activities. The steering committee will also be tasked with providing feedback to CMS on the pilot and identifying barriers to successful implementation. Hospitals from the three pilot states will take part in a pilot satisfaction survey in March or April 2003. Information from this survey will be confidential. The Agency for Health Care Research and Quality (AHRQ) selected hospitals in each state in February 2003. The survey will be administered through the mail with follow-up contact made by telephone. In order to obtain a representative sample of hospitals in the pilot satisfaction study, the Commission staff is requiring that each acute care hospital participate in the pilot. This will also satisfy the legislative requirement that the Commission collect satisfaction data.

The Delmarva Foundation hosted a kick-off meeting on February 10, 2003. All Maryland hospitals attended this meeting. The Commission sent a follow-up letter to all hospitals on February 24, 2003 notifying them of the revised timeline, clarifying that neither the Commission, nor CMS, were requiring hospitals to publicly report the congestive heart failure and pneumonia clinical measure results on the CMS public website, and clarifying privacy/confidentiality concerns related to the Health Insurance Portability and Accountability Act (HIPPA).

In addition to the Pilot Project, a national coalition of healthcare organizations, including the American Hospital Association (AHA), the American Association of Medical Colleges (AAMC), the Federation of American Hospitals (FAH), the National Quality Forum (NQF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), announced a voluntary initiative that will encourage every hospital in the country to collect and publicly report quality information.

The "starter set" of measures will draw from three of JCAHO's Core Measure Sets: Acute Myocardial Infarction (AMI), Congestive Heart Failure (CHF) and Community-Acquired Pneumonia (CAP). Initially, Maryland hospitals will be able to report measures from just two of the areas (the CHF and CAP measures that are already being collected), but will be strongly encouraged to report from all three as soon as possible. This information, in addition to being on the MHCC website as currently in process, will also be on CMS's website (www.medicare.gov) sometime this summer.

Ambulatory Surgery Facility Report Card

Chapter 657 (HB 705) of 1999 also requires the Commission to develop a performance report for Ambulatory Surgery Facilities (ASF). The required progress report has been forwarded to the General Assembly. The Commission is currently developing a web-based report that will be available by April 2003. The website will contain structural (descriptive) facility information including the jurisdiction, accreditation status, and the number and type of procedures performed in the past year. The site will also include several consumer resources.

An ASF Steering Committee will be convened to guide the development of the report and will consist of representatives from a multi-specialty facility, a large single specialty facility, an office based facility, a hospital based facility, and a consumer representative. An exploratory meeting was held with a subset of this group on January 28, 2003. Subsequently, the Steering Committee

provided input on several of the proposed web pages including a consumer checklist, glossary, and list of resources.

HMO Quality and Performance

Distribution of 2002 HMO Publications

Cumulative distribution: Publications released 9/23/02	**9/23/02- 2/28/03**	
	Paper	**Electronic Web**
The 2002 Consumer Guide to Maryland HMOs & POS Plans **(25,000 printed)**	20,925	Interactive version 847 visitor sessions **.pdf version:** data pending
2002 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland **(700 printed)**	604	**Visitor Sessions** = data pending

2003 Policy Report (2002 Report Series) –
Released January 2003; distribution continues until January 2004

Policy Report on Maryland Commercial HMOs & POS Plans (1,200 printed)	728	**Visitor Sessions** = data pending

Shipments of the recently released *2003 Policy Report,* along with reference copies of the *Consumer Guide* and *Comprehensive Report,* were made to depositories and academic libraries as part of the scheduled winter distribution. Public library mailings included an order form allowing branches to request additional HMO publications. Three Montgomery County libraries responded with requests to restock depleted inventories of the *Consumer Guide*. In past years, public libraries received automatic re-stocking shipments of the *Consumer Guide.* However, that method lacked any mechanism for Division staff to judge public consumption of the report through this venue. Based upon the feedback supplied by the order forms sent in spring 2002 and winter 2003, staff feels confident this approach will prevent "dumping" of the publication by branches saturated with unsolicited copies.

In a letter updating his constituents about the legislative session, Senator Teitelbaum generated interest in the *Consumer Guide* after notifying residents of District 19 of its availability. HMO Division staff provided the Senator's office with a supply to send copies directly to requestors.

With circulation to regular outlets completed, staff focused on further organizing distribution operations. Consolidation of historic distribution data, shipping protocols, and related correspondence for each category of recipients that comprise mass mailings into a single manual was accomplished in February. It is expected that the manual will optimize efficiency by improving the logistics of where/how information is maintained.

During February, an application was submitted to the Library of Congress to copyright each of the 2002 HMO publications.

2003 Performance Reporting: CAHPS Survey and HEDIS Audit
HealthcareData.com (HDC), the audit contractor, provided MHCC with an electronic copy of the Baseline Assessment Tool (BAT) for eight plans. In its completed form, the document allows the auditor to review the details of a plan's system for collecting and reporting HEDIS data, as well as learn about its operational and organizational structure in preparation for the site visit. One plan submitted an incomplete document and staff is in the process of determining if sanctioning the plan is warranted and whether to postpone the site visit due to insufficient information. Division staff continued to move forward in reviewing the BATs. A general review of the instrument is an oversight activity used by this Division to monitor the contractor for consistency in work performance among the individual auditors. Due to the volume of each document, the review will continue into March. Additionally, staff has used the documentation review to prepare for site visits to PHN and Coventry scheduled in March. HDC, at the request of the Commission to satisfy state requirements for out-of-state activities, provided a letter of invitation to attend the Coventry site visit in Delaware.

As a check on the survey process, HMO Division staff was "seeded" for each of the four pieces of mail being sent to a sample of 1100 members from each plan. To date, two waves of mailing have been completed. This marks the first year enrollee distribution by product type has been compared to the distribution by product type within the sample. Sample frequencies demonstrate that enrollees in each product, HMO and POS, are proportionally represented in the survey sample for each plan.

Proposed Changes to HEDIS 2004
HealthcareData.com notified MHCC and health plans of NCQA's proposed changes to HEDIS 2004. Eleven new measures ranging from service measures to substance use treatment measures are under consideration for next year. Additionally, NCQA has proposed changes to seven measures for which plans currently report their results. The suggested changes integrate the latest clinical guidelines developed by leaders in various medical fields and guidelines developed by federal agencies. Staff began examining the changes in February and will respond during the March public comment period as appropriate.

Report Development Contract/Optional Unit Work
In preparation for focus group planning sessions with NCQA, staff conducted a limited survey of large employers in Maryland to reestablish what quality information they make available to employees. Overwhelmingly, large employers responded that they do not provide any type of quality information. The nine employers in this survey offering HMO/POS products but not offering quality measurement information have a combined work force of 30,000-46,000 employees.

Quality Information Provided by Maryland's Largest Employers

Businesses Contacted	14
Businesses Contacted Offer Commercial HMO, POS, or Both	11
Businesses Make *Guide* Available	1
Businesses Provide Quality Measures & Accreditation Status	1
Businesses Provide Accreditation Status Only	1
Businesses Provide No Quality Measures or Accreditation	8

Planning sessions will take place in March with a strong focus toward examining employer attitudes on quality information.

Availability of After-Hours Care and Urgent Care Utilization
In response to disparate utilization data reported in 2002, a supplemental urgent care questionnaire was sent to plans in February. The purpose of the questionnaire was to establish a uniform definition for urgent care centers, thus setting the parameter for which providers and visits the plans should include in their data reporting this spring. Additionally, details about plans' policies on urgent care were obtained. This early information shows that since the Commission first began collecting data on urgent care last spring, access to this level of care has increased. Five plans reported an increase in the number of facilities available for member access. Seven plans cover urgent care services for all enrollees, while one plan offers it as a benefit option and one plan does not cover in-area urgent care services. The eight plans with urgent care coverage report that members have direct access

HEALTH RESOURCES

Certificate of Need

During February 2003, staff issued on the Commission's behalf a total of three determinations of coverage by Certificate of Need review. Two determinations involved acquisitions of existing facilities or services. The recent announcement that Sunrise Assisted Living, Inc. intended to acquire Marriott Senior Living Services required that Sunrise provide written notice to the Commission that the entities acquired will include the 60-bed nursing facility at Bedford Court, a continuing care retirement community in Montgomery County. The Bedford Court facility was the only component of Marriott's extensive Maryland portfolio of senior communities actually owned by Marriott Senior Living Services, although the company managed two other nursing facilities in Montgomery County. Marriott's management company will also continue to manage the health care center at Bedford Court. Also during February, staff issued a determination of non-coverage by CON review to Heartland Home Care, for its acquisition of the home health agency operated by Jewish Social Services, which is authorized to provide these services in Montgomery and Prince George's Counties. The Jewish Social Services Agency will retain its hospice program.

Also during February, staff authorized a three-month extension to the temporary delicensure authority of HealthSouth Physicians Surgery Center, on Wilkens Avenue in Baltimore City. The Center requested this extension in order to complete negotiations on a potential sale to several of its physician members.

Acute and Ambulatory Care Services

Staff has established the Acute Care Hospital Planning Workgroup to discuss issues raised concerning the proposed revisions to the State Health Plan chapter on acute inpatient services, COMAR 10.24.10. A preliminary draft of the proposed SHP changes, including proposed revisions to the acute care bed need projection methodology, were both released for informal public comment in 2002. The first workgroup meeting was held on January 24, 2003. The agenda included a discussion of the Hospital Census Survey conducted by the Maryland Hospital Association and MHCC over one week in September. Based on the views of the majority of the workgroup members, MHA and MHCC decided to repeat the survey during the winter quarter.

Hospitals have received the survey instrument and instructions from MHA, and are expected to complete the survey by March 17th. Staff anticipates that this information will contribute to revisions to this State Health Plan chapter. The second meeting of the workgroup was held on March 7th. The agenda included a discussion of options to address apparent conflicts between the two approaches to increasing acute care bed capacity in the state's licensure process and the certificate of need law.

On February 20, 2003, staff participated in a meeting between health resources staff and representatives of North Arundel Hospital regarding the development of a new obstetric service at that hospital. A certificate of need application is expected from the hospital later this year.

Long Term Care and Mental Health Services

Staff participated in assisting the Certificate of Need Division in the review and analysis of the issues surrounding the Sheppard Pratt project that will be presented at the March Commission meeting. Material developed for this review will be used in the update of the State Health Plan section on psychiatric services. Data from the 2001 Maryland Long Term Care Survey was provided to Myers and Stauffer in order to allow them to validate the minimum data set (MDS) data that they are preparing for the Commission.

Staff prepared background historical information to assist in developing a Commission position on SB 732. This bill addresses Certificate of Need review of hospice and the concept of statewide authority for hospice programs that were grandfathered when Certificate of Need was established for this service.

Work is progressing in development of a background paper on the subject of Post Acute Care. This includes trend analysis of data for both the chronic hospital and hospital-based skilled nursing facility settings. Research is being conducted on both federal and state rules governing reimbursement in these emerging areas.

Specialized Health Care Services

The February 19th meetings of the Interventional Cardiology Subcommittee and the Steering Committee of the Advisory Committee on Outcome Assessment in Cardiovascular Care were cancelled because of the record-breaking snowstorm. The Interventional Cardiology Subcommittee met on March 10, 2003 to review and discuss state health planning policy regarding elective angioplasty and a Draft Statement on Acute ST-Segment Elevation Myocardial Infarction: Recommendations of the Interventional Cardiology Subcommittee. The Steering Committee will meet at 6:00 p.m. on March 26th to discuss the proposed final recommendations of the four subcommittees, and options for the structure and composition of an ongoing advisory committee. Meetings of the Advisory Committee are held in Room 100 at 4160 Patterson Avenue, Baltimore, Maryland.

Staff continued to collect data on the utilization of bone marrow and stem cell transplant programs in Maryland, the District of Columbia, and Northern Virginia for the fourth quarter of 2002. The submission of data by one program in Maryland is pending. The number of reporting programs has decreased from ten to nine. The program at Sinai Hospital closed in August 2002 because of noncompliance with a State Health Plan requirement to achieve minimum volumes. The survey data are used to examine policy options for the State Health Plan chapter on Organ Transplant Services, and to monitor the utilization of services.

At its meeting on February 20th, the Work Group on Rehabilitation Data reviewed and discussed the discharge abstract data for the third quarter of 2002, the schedule for submission of facility and discharge data in 2003-2004, and the Maryland system for grouping rehabilitation discharges. The Work Group will hold its next meeting at 1:00 p.m. on June 5th in Room 101 at 4160 Patterson Avenue, Baltimore, Maryland.